WISCONSIN MEDICAID

PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is mandatory to receive prior authorization (PA) of certain procedures/services/items. Only number-stamped originals of this form will be accepted. In addition to the Prior Authorization for Hearing Instrument and Audiological Services (PA/HIAS1), hearing instrument specialists and audiologists must include a completed Prior Authorization/Hearing Instrument and Audiological Services (PA/HIAS2) attachment. Hearing instrument specialists must also include a completed Prior Authorization/Physician Otological Report (PA/POR).

Providers may submit PA requests, along with all applicable service-specific attachments, by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may submit PA requests with attachments to:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — Name and Address — Testing Center
Enter the name and complete address (street, city, state, and Zip code) of the testing center. *No other information should be entered in this element, since it also serves as a return mailing label.*

Element 2 — Telephone Number — Testing Center
Enter the telephone number, including the area code, of the testing center.

Element 3 — Processing Type
Processing type “123” (hearing instruments) is preprinted in this element.

Element 4 — Testing Center’s Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the testing center.

Element 5 — Name — Referring Physician
Enter the name of the referring physician.

Element 6 — Referring Physician’s UPIN, Medicaid, or License Number
Enter the six-digit Medicare Universal Provider Identification Number, eight-digit Medicaid provider number, or license number of the referring physician.

SECTION II — RECIPIENT INFORMATION

Element 7 — Name and Address — Recipient
Enter the recipient’s last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient’s name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS. Enter the complete address of the recipient’s place of residence, including the street, city, state, and Zip code. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 8 — Recipient Medicaid ID Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the recipient's Medicaid identification card or the EVS to obtain the correct identification number.

Element 9 — Sex — Recipient
Enter an "X" in the appropriate box to specify male or female.

Element 10 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/YY format (e.g., September 8, 1966, would be 09/08/66).

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 11 — Diagnosis — Code and Description
Enter an *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code and written description of the recipient's diagnosis.

Element 12 — Performing Provider Number
Enter the eight-digit Medicaid number of the provider who is requesting the service; this provider will not necessarily be the one performing the service. Enter a number here *only* if this number is different from the testing center's Medicaid provider number listed in Element 4.

Element 13 — Procedure Code
Enter the appropriate procedure code for each hearing instrument requested.

Element 14 — Modifiers
Enter the modifier(s) corresponding to the procedure code listed if a modifier is required by Wisconsin Medicaid. Refer to the Hearing Services Handbook for a list of appropriate modifiers.

Element 15 — POS
Enter the appropriate two-digit place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

Element 16 — Description of Service
Enter the procedure code description of the hearing instrument requested.

Element 17 — QR
Enter the appropriate quantity requested for each procedure code listed.

Element 18 — Charge
When the service is a complete hearing instrument package, enter the actual or best estimate of the net cash outlay cost. For all other services, enter the usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to *Terms of Provider Reimbursement* issued by the Department of Health and Family Services.

Element 19 — Total Charges
Enter the anticipated total charge for this request.

Element 20 — Signature — Requesting Provider
The original signature of the requesting audiologist or hearing instrument specialist must appear in this element.

Element 21 — Provider Type
Check the appropriate box to indicate whether the requesting provider is an audiologist or a hearing instrument specialist.

Element 22 — Date Signed
Enter the month, day, and year the PA/HIAS1 was signed (in MM/DD/YY format).

Do not enter any information below the signature of the requesting provider — this space is reserved for Wisconsin Medicaid consultants and analysts.